MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
February 19, 2015 - 9:30 am to 1:00 pm
United Way Conference Center, Room F
1111 9th Street, Des Moines, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Neil Broderick
Thomas Broeker
Richard Crouch
Lynn Grobe
Kathryn Johnson
Betty King
Sharon Lambert
Geoffrey Lauer
Brett McLain (by phone)
Rebecca Peterson
Michael Polich
Patrick Schmitz
Marilyn Seemann
Suzanne Watson

MHDS COMMISSION MEMBERS ABSENT:

Marsha Edgington
Deb Schildroth
Representative Dave Heaton
Representative Lisa Heddens

OTHER ATTENDEES:

Rachel Anderson	Mercy Center for Rehabilitative Medicine
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon	U of Iowa Center for Disabilities and Development
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Tom Brown	Advisory Council on Brain Injury
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS Targeted Case Management
Marissa Eyanson	Easter Seals Iowa
Connie Fanselow	MHDS, Community Services & Planning
Jim Friberg	Department of Inspections and Appeals
Melissa Havig	Magellan Health Services
Jan Heikes	MHDS, Community Services & Planning
Mary Hodapp	Woodward State Resource Center
Jane Hudson	Disability Rights Iowa
Diane Jackson	Heart of Iowa Community Services MHDS Region
Laura Larkin	MHDS, Community Services & Planning
Bob Lincoln	County Social Services MHDS Region
Marcy Murphy	Southeast Iowa Case Management
Tammy Nyden (phone)	Iowa Mental Health Planning Council/NAMI
Caitlin Owens	U of Iowa Center for Disabilities and Development
Emily Reyes	Woodward State Resource Center
Peter Schumacher	U of Iowa Center for Disabilities and Development
Rick Shults	MHDS Division Administrator

Deb Eckerman Slack	ISAC Case Management and MHD Services
Jennifer Vitko	Wapello County/South Central Behavioral Health Region
Ryanne Wood	Southeast Iowa Link MHDS Region

WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:35 a.m. and led introductions. Quorum was established with thirteen members present and one participating by phone. No conflicts of interest were identified for this meeting.

APPROVAL OF MINUTES

Richard Crouch made a motion to approve the minutes of the January 15, 2015 meeting as presented. Tom Broeker seconded the motion. The motion passed unanimously, with Brett McLain voting by phone. Betty King joined the meeting after the vote.

CHILDREN'S MENTAL HEALTH SERVICES REPORT

Laura Larkin presented an overview of the Implementation Status Report Regarding the Mental Health Service System for Children, Youth, and their Families, a legislatively mandated report that DHS submits to the General Assembly and the MHDS Commission every January. The report was created to inform the legislature on progress toward establishing a statewide children's mental health system in Iowa for children with serious emotional disturbances and other emotional disorders. The report was initiated in 2008, with money set aside for the development of children's services. Since then, four systems of care (SOC) projects have been established in 14 counties and have received funding through state appropriations.

The original purpose of the funds was to provide care coordination and wrap around funds for children to remain in their families and communities. Since then, Integrated Health Homes (IHHs) have been implemented statewide and they are now providing those functions for Medicaid-covered children. The SOC programs are currently focused on serving non-Medicaid eligible children and helping them get access to services that would not otherwise be available to them, such as BHIS (Behavioral Health Intervention Services) or respite care.

The four systems of care programs are:

- Community Circle of Care
    - It covers 10 counties in northeastern Iowa
    - The FY15 state appropriation was $1.18 million
    - The program has served 620 children in FY15
- Central Iowa SOC
    - It covers Polk and Warren counties and is operated by Orchard Place
    - The FY15 state appropriation was $211,000
    - The program has served 63 children in FY15 and has a waiting list

- Four Oaks
    - It covers Linn and Cerro Gordo counties
    - The FY15 state appropriation was $135,000
    - The program has served 36 children in FY15 and has a waiting list of about three
- Tanager Place
    - It covers Linn and surrounding counties
    - This is a new program that started during FY15
    - The FY15 state appropriation was $110,000
    - The program has served eight children since September 2014

The SOC programs are also integrated health homes and are serving children through both programs.

The report includes a table showing the FY14 outcomes for three performance measures related to keeping children and youth out of more restrictive placements, avoiding involuntary commitments, and school performance. These are children who have high needs, who are at risk of out of home placement, and have been getting good outcomes through SOC provision of family support, care coordination, and flexible funding.

The first SOC program, the Community Circle of Care, was initially funded with a SAMHSA (Substance Abuse and Mental Health Services Administration) grant. When that grant ended, the state assumed the costs. The Central Iowa and the Four Oaks programs were funded through a state RFP (Request for Proposals) process, and the Tanager Place program was funded through a direct legislative appropriation. The total appropriation for the SOC programs for FY15 was about $1.6 million. Funding for them was requested in the DHS FY16 budget, but there was no state funding for the SOCs included in the Governor's FY 2016 budget.

Neil Broderick commented that the Governor's decision not to include funding in his SFY16 budget does not seem consistent with the good outcomes reported or the quality of the work that has been done by the systems of care programs. Theresa Armstrong said it is true that there have been good outcomes and the work has been successful, but some tough decisions have been made relative to the huge deficit in the DHS Medicaid budget. This was identified as an area where some cost containment could be made. Neil said it does not make sense to cut a program that is working for kids and costs much less than placing them in a PMIC (Psychiatric Medical Institution for Children) or other residential setting. He said it seems like a small budget item that should not be cut because it is making a much larger positive impact.

MHDS UPDATE

MHDS Staff Changes - Theresa Armstrong began with updates on MHDS staff:

- Connie Fanselow has accepted a new Executive Officer position within MHDS and will be focusing on services for individuals with intellectual and developmental disabilities.
- Peter Schumacher has been hired by the Center for Disabilities and Development (CDD) and will be taking over Connie's contract position to support the MHDS Commission and the Mental Health Planning Council. Peter will be housed at MHDS.
- Rose Kim has also been hired by CDD and will also be housed within MDHS. Rose will be working on outcomes and data.

Medicaid Modernization – Rick Shults gave a brief overview of the RFP posted by DHS on Monday for Medicaid Modernization, which is to establish a Medicaid managed care plan. He indicated that there will be many opportunities for people to give input and submit their comments as part of the process. He hopes to have representatives from IME (Iowa Medicaid Enterprise) to talk more about it at next month's meeting to provide some details and answer questions. The RFP is available for review online at: https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Rick said this is a two track process. First, it is a DHS procurement process, which means that it must be handled formally and cautiously because all information must be shared with potential bidders in fair, transparent manner that ensures anyone interested in submitting a bid receives the same information and no one gets an unfair advantage. Second, this is different than the usual bidding process because the Department wants all other stakeholders to be able to share input and comments and it is likely that an amended RFP will be released to incorporate some of that input.

Rick noted that, while the majority of Medicaid operates with a fee-for-service model, a portion of Medicaid members are already enrolled in managed care programs:

- MediPASS
- Iowa Plan (Magellan)
- Health Maintenance Organization (HMO)
- Iowa Health and Wellness Plan
- Dental Wellness Plan
- NEMT (Non-Emergency Medical Transportation)
- PACE (Program for All Inclusive Care for the Elderly)

Except for PACE, none of the existing managed care programs have a comprehensive benefit plan. The RFP is for the development of a comprehensive model that covers more people and gives them choices of providers. The Department is sensitive to making sure this RFP ensures good quality services, follows the principles that have been established, supports integration, and continues to improve mental health services. There are three central goals:

- Improved quality and access
- Greater accountability for outcomes
- Creating a more predictable and sustainable Medicaid budget

The single system of comprehensive care will embody a wide array of Medicaid services, including physical health care, behavioral health care, and long term services and supports. Behavioral health care will include mental health services, substance use treatment, integrated health homes, PMICs, and the Children's Mental Health Waiver. Long term services and supports will include HCBS Waivers (other than CMH), nursing facilities, and ICF/ID (Intermediate Care Facilities for persons with Intellectual Disabilities) services.

The RFP is seeking two to four successful bidders to deliver high quality health care and health care coordination statewide that will result in quality outcomes for Medicaid members. The Department is also seeking comments on the proposal through a public process and it has been anticipated in the timeline that the RFP will be amended based on the input received, with an amended version released near the end of March. The estimated award date is July 31, 2015, with an estimated start date of January 1, 2016.

A webpage has been established as a source of information [the link is shown above]. Several documents, including the RFP with the specific procurement steps, technical pieces, and the scope of work are posted for public review. Rick said that he plans to have someone from IME walk the Commission through a more extensive presentation next month. IME has scheduled a series of public meetings and will be going around to a variety of groups to talk about the initiative over the next several weeks. Comments can be submitted through March 20. The email address for submitting public comments is: MedicaidModernization@dhs.state.ia.us

Geoff Lauer commented that there are services offered in the current Medicaid program that do not seem to be described in the RFP, including some services to persons with brain injuries and children's services. He also said that the RFP uses the term "traumatic brain injury" rather than the term "acquired brain injury" which is now used and is more inclusive. Rick indicated those are the kind of comments that should be submitted to IME so that they can be addressed through the public input process.

Jane Hudson commented that Disability Rights Iowa will be working on a side by side comparison with the guiding principles for successfully enrolling people with disabilities in managed care plans that have been published by the National Council on Disability. She asked if the State Resource Centers will be run by a managed care provider. Rick responded that they would still be operated by DHS and would be one of the service providers that would offer services under the umbrella of the managed care entities. Jane also asked if more staff would be focused on quality assurance and oversight. Rick responded that a plan will be put together to address those issues.

Tom Bouska asked if the RFP addresses how the transition to managed care will be made. Rick responded that the RFP does include descriptions of how transitions are to take place.

Patrick Schmitz asked if the managed care organizations will each have a different set of services or if services will all be the same. Rick responded that each managed care

organization will be required to cover all current Medicaid services. The service array is included in the RFP, although bidders will have some ability to manage services within that array. Rick suggested thinking of it as insurance coverage. Private insurance companies have agreements with hospitals, but they do not run the hospitals, and different companies may have different agreements. The hospitals provide services and bill the insurance company for covered costs per their agreement.

Rick was asked to clarify the relationship between IME and the managed care organizations. He explained that IME is part of DHS. The managed care organizations will have performance based contracts with DHS that have to be managed and overseen by DHS staff to ensure that the requirements of the contract are achieved. IME is already managing contracts for the provision of managed care and is experienced in making sure that people are getting the services they need through those contracts. There are some functions that will change, such as working with providers to set rates and handle claims.

Jane Hudson commented that she did not see employment services listed in the RFP. Rick responded that most employment services are paid through the HCBS Waivers so are included under that umbrella. Jane noted that the time from the award to the start of the contract is scheduled to be only six months and asked what will happen during that time and how Medicaid members will be informed about the changes. Rick responded that the Department is currently working on all the things that will need to happen in the beginning phases and the variety of ways people need to access information. Rick noted that nationwide, 70% of all Medicaid recipients are served under managed care systems and many other states have already made this transition, so Iowa can learn from them.

Suzanne Watson asked if Rick could say anything about how this will affect targeted case management (TCM). Rick said he hopes to have some clearer information about that next month.

Teresa Bomhoff asked what happens if people do not choose a managed care organization. Rick responded that they will have the opportunity to choose, but at some point if they do not make a choice, they would be assigned to a provider. Kathy Johnson asked if there is a process for how quickly and how often people can make changes. Rick responded that there will be a process for people to change MCOs.

Neil Broderick asked how moving to managed care benefits consumers and taxpayers. Rick responded that Medicaid recipients can expect to get a more comprehensive approach to their care because there will be the opportunity to look at the whole person and work to better integrate services to address all their different needs. IHHs are a good example of how that can be done. When all chronic health conditions are covered and there is an emphasis on prevention and care coordination, people stay healthier, which is certainly good for them. Healthier people also cost the system less.

Several people expressed concerns about the short timeline for such a major change. Rick responded that it is an ambitious timeline, but said he is confident it can be accomplished.

Tom Brown asked Rick to clarify what he meant when he said input would be "considered." He said he believes there are some errors or omissions in the RFP that should be corrected. Rick responded that if specific items are identified that are incorrect or incomplete, they will be corrected, but there are also going to be many points of view expressed and those things will be considered. Some suggested changes may be made and others may not, for a variety of reasons.

Tammy Nyden commented that children's system of care services are not available throughout the state and asked if the RFP should address those types of services statewide and require the MCO provider to fill in gaps. Rick responded that the services in place now will continue to be delivered under the RFP. Tammy said she is concerned that services are not being delivered now to children with SED (Serious Emotional Disturbance) in some counties of the state. Rick asked her to provide specific information about that to the Department through the RFP email input process.

Kathy Johnson asked if CMS (Centers for Medicare and Medicaid) has approved the RFP. Rick responded that the Department has been in contact with CMS, but there will be an entirely separate process for CMS approval that will follow technical steps and will happen at a later stage.

Teresa Bomhoff said she has been told that children and adolescents cannot be placed into a managed care system without having a waiver from the federal government. Rick responded that is among the items that the Department will be working with CMS to resolve.

Rick said that more detailed presentations on Medicaid Modernization will begin toward the end of this month.

LEGISLATIVE UPDATE

Clarinda and Mt. Pleasant MHIs – The budget recommendation is for the Clarinda and Mt. Pleasant MHIs to receive no funding for SFY16, which begins July 1, 2015. They are currently providing a wide variety of services, but will need to close by July 1 without funding for the new fiscal year.

Mt. Pleasant MHI has three programs that provide different types of services:

- An inpatient hospital psychiatric unit with nine beds for adults. They had seven admissions in calendar year 2014.
- A dual diagnosis program that treats individuals with a stable mental illness and a co-occurring substance use disorder. That program has 19 beds. During calendar year 2014 it operated well below capacity with about eight people participating at any given time. It relies on revenue from people participating in

the program to pay for its cost and there were not enough participants last year to support it.
- A substance use disorder residential treatment program with 50 beds, which had a census between 25 and 30 for most of the 2014 calendar year.

Clarinda has two inpatient mental health programs:
- An inpatient hospital psychiatric unit with 15 beds, eight to nine of which were in use most of the time. Thirty-seven percent of those were voluntary admissions, and most were from Page County or that area of the state. By contrast, more than 95% of admissions to the Cherokee and Independence MHIs are involuntary commitments.
- A geropsychiatric program with 20 beds. The individuals in this program require very close supervision, and include some individuals with a history of sexual offences. Most people in this unit have been in long term care for years, and there have been no admissions from the general public to this unit for quite some time.

To balance these closures, up to 30 inpatient adult psychiatric beds will be added at the Independence MHI. If all 30 beds are added, there would be an increase of six adult psychiatric beds from the number currently in the system. The Department is in the process of identifying what the additional staffing needs will be to open more beds at Independence. There is a geographic shift in the MHI beds, and there will be fewer beds in the southern part of the state, but overall there will be more MHI beds. Patrick Schmitz asked if there was any thought given to adding some of the beds at Cherokee. Rick responded that this plan was the most expeditious way to shift capacity.

Rick referred to a map on page six of the MHI Realignment handout, showing the state's array of core plus and inpatient mental health services. He said the Legislative Services Agency (LSA) helped to gather the information. Rick explained that the map shows black ovals containing two numbers. The outside number represents the number of actual beds and beside it is the number of beds that have staff support to be used for services. Even though the MHIs have sprawling campuses, they have limited numbers of staff, which limits the number of beds available for use.

Teresa Bomhoff expressed concern that MHI census numbers are down because they have been denying admission, not because the need has been reduced, and said that hospitals have been working to build capacity. Rick said the Department is very supportive of community hospitals that want to provide psychiatric services because that gets services scattered throughout the state. He said MHIs are not designed to fill the entire capacity for acute mental health care in the state; they are just one part of the overall array of services that need to be provided statewide. There are some new community beds being developed, including a 12-bed facility in Wapello County. There is some expansion happening in Des Moines at Iowa Lutheran and Broadlawns Hospitals. That expansion will take some time, but it is moving forward. DHS is meeting with others and talking about how the resources at Clarinda and Mt. Pleasant, including both staff and facilities, can be used in other ways. Rick noted that the

hospital bed tracking bill did not pass the legislature last year, but there still may be ways of tracking beds developed in the absence of that particular legislation.

Sharon Lambert commented that it is hard for her to understand why the MHI beds have not been fully used when she has had the experience of waiting many hours with a family member in a hospital emergency room while a bed is located. She also expressed concern about maintaining sufficient capacity for people who are in crisis to have access to a safe place for their protection and the protection of others. Teresa Bomhoff expressed concern about the distances people may need to travel to be admitted to a hospital for treatment. Richard Crouch said that the closure of the Clarinda MHI will be a burden on the sheriff's departments in southwest Iowa because it takes two law enforcement personnel away from their regular duties for more than six hours to transport someone to the Cherokee MHI.

Rick said DHS is making an overt effort to work with regional CEOs, mental health providers, and substance use treatment providers in southern Iowa. DHS leadership is meeting with key leaders from the area and will see what the Department can do to support them. Rick said he and Kathy Stone will be meeting tomorrow with substance use disorder treatment providers in the southeastern part of the state and the following week they will be meeting with mental health providers. He said there is now capacity of about 50 beds for out of home crisis services in the state because of the efforts of the MHDS regions. Regions are developing jail diversion, community crisis, and other services across the regions at a rapid pace.

Geoff Lauer asked if there are transition plans for the individuals currently at Clarinda and Mt. Pleasant. Rick responded that the transition process is beginning and work is being done to identify appropriate alternatives. Transition plans will be specific to each individual. The Department expects to have everyone successfully placed by mid-June. Admission to the inpatient psychiatric program will stop the first of April. The goal is that anyone admitted will have time to complete their treatment and be able to move to a lower level of care when they leave the MHI.

Admissions to Mt. Pleasant have been discontinued. There is currently no psychiatrist on staff at the facility. There is a full time advanced registered nurse practitioner on site. Physicians from other DHS facilities and through contract arrangements also provide support. The individuals currently at Mt. Pleasant are expected to complete their treatment within the next 30 to 60 days. If ongoing outpatient treatment is needed, DHS will work with guardians and the courts to transfer individuals to Cherokee or Independence. There is currently no one in the dual diagnosis program. The substance use disorder treatment program will continue to accept people until early May. That will allow individuals admitted to the program time to complete their treatment and be discharged before July 1. The superintendents at both facilities have met with their staff and shared information about the transitions with them. Jane Hudson asked where the $10 million in savings is going to go. Rick responded that it is part of the additional $70 million that the Governor is putting into the DHS budget to cover increased costs, which include MHDS services.

Betty King said the involvement of family is very important whenever an individual is moving or anticipating a move to a different facility and asked how families will be included in the decision-making process. Rick responded that the individuals in the geropsychiatric program will be affected most because it operates like a long term care facility and they have been at the MHI for a long time. The Department is already working with families. Some are interested in getting individuals closer to family if appropriate services can be found in their area. Meeting individual needs for care and treatment is the primary concern and moving them closer to family members or a support network is also an important consideration. The criteria will be based on the best interest of the individual. Betty asked who is making those decisions. Rick responded that each facility has social workers and nursing staff who know the individual's needs and can work with families.

Neil Broderick asked what will happen to the buildings and grounds, and if the remaining tenants can support the costs of operation or if efficiencies will be lost. Rick responded that the Clarinda Academy will continue to operate under an agreement with the Department of Corrections, serving at least 150 youth. There is also a private 15-bed substance use treatment program at Clarinda that will continue. The Department is interested in talking to people about using the facilities for other things. They will need to be maintained and it would be preferable to utilize them. Teresa Bomhoff asked if the loss of the MHIs on the two campuses will mean increased costs for the prison facilities. Rick responded that there may be some increased costs to the correctional facilities, and they have money budgeted for that purpose.

Ryanne Wood commented that in southwestern Iowa the dual diagnosis beds were being used for acute care, which helped minimize the need for transport. She said there is no lack of demand for beds and expressed concern that because the certification process for adding new acute care beds takes considerable time, it will be a lengthy process to rebuild capacity.

Suzanne Watson said that her region recognizes this as systems change in the Clarinda area and knows that change does not happen overnight. They want to establish some crisis stabilization residential beds and are working to create a pilot project for doing that. They are also working with hospital emergency departments to build relationships and promote an education component for ER doctors to help them better understand psychiatric issues. She said it takes time to gather information to help doctors and crisis mobile response make sure they are sending the people to the settings and services that best fit their needs. It involves retraining and building trust in the community. Rick Shults noted that he has been extraordinarily impressed by the way the key players in that part of the state are looking at opportunities to build and improve services.

MHDS Redesign Equalization – Rick noted that there is no recommendation to include $30 million for equalization in the human services budget. The Department has developed a funding recommendation that he presented to the Health and Human Services Joint Subcommittee on February 12. He said counties and regions also shared their perspectives with the subcommittee.

The funding recommendation has three parts:

- First, establishing an amount of money for funding non-Medicaid regional MHDS services based on SFY15 funding minus the full savings from the Iowa Health and Wellness Plan:
    - About $157.8 million from the maximum existing MHDS levy, general fund, and SSBG (Social Services Block Grant)
    - Minus about $27.7 million ($20.2 million Medicaid offset($10.1 million savings for 6 months x 2) times a 1.37 growth factor for the increased participation in the Iowa Health and Wellness Plan from SFY14 to SFY15)
    - Results in a $130.1 million funding level

- Second, identifying available funds:
    - About $108.5 million from the SFY16 MHDS property tax levy, which is the maximum levy for next year because of Medicaid offset and reductions
    - Plus about $13.9 million from federal block grant funds (distributed pro rata, in proportion to each region's share of the funding level amount)

- Third, the difference between the funding level (part 1) and the available funds (part 2) would be made up by county fund balances

The $13.9 million represents the funding expected to be available from the Social Services and Community Mental Health Services Block Grants. Prior to redesign, about $11.7 million from the Social Services Block Grant was used for funding services to people who did not have a county of legal settlement, through the State Payment Program. The vast majority of those individuals are now funded by their county of residence. The money would still go to regions, but be distributed in a different way. About $2.2 million of Community Mental Health Services Block Grant funds that has been contracted to community mental health centers (CMHCs) to fund training and services would be shifted to the regions with legislative approval. The funds would be distributed on a proportional basis so that all regions would receive a proportionally equal share based on the gap between their share of the $130.1 million funding level and what they can raise in property taxes. Rick added that these funds would not completely fill that gap and the difference would have to be made up from county/regional fund balances.

Rick said county representatives wanted to make it clear that about half of the counties are already considering lowering their tax levies, at least partially in connection with managing their fund balances. There is interest in having a better understanding of longer term use of fund balances. The Department would work with them on those issues. Some counties have fund balances over 25% but want to take a long-term thoughtful approach to using those funds. Suzanne Watson said her county has a large fund balance and has developed a five-year plan to lower it. She said they reduced their levy because they were told they have to get the balance down to 25%. They want to equalize what each county is contributing to the region and keep the levy rates fair to all the taxpayers in the region, while managing the fund balances.

Patrick Schmitz asked what the reasoning is behind moving the $2.2 million from the Community Mental Health Services Block Grant from CMHCs to regions. Rick responded that there is an advantage to giving regions the ability to manage the money since it is used to pay for non-Medicaid services. He said he recognizes that there is also a need to be forward thinking about how to help CMHCs address the loss of funding for their services.

Tom Broeker commented that regions need ongoing and predictable revenue so they know what long term programs and services they can sustain. Suzanne Watson added that she would like legislators to recognize that the high fund balances counties currently have are a result of the cyclical way the former funding formula worked, not because they have put money away or failed to spend available money on services.

Sharon Lambert said that some of the efforts coming out of redesign have been a great benefit for her grandson. He now has a licensed psychiatrist and a family care provider, is enrolled in an integrated health home, and is more stable than he has been in about five years. She said she worries that some of the system improvements that have been made will be lost if there is not enough funding to support them. Rick said that the currently financial circumstances are completely different than they were 18 months ago, so we need to figure out how to arrive at a sustainable funding system with the circumstances we have now.

Bob Bacon posed a question about who has responsibility for capacity building in the system. Rick responded that accountability is a critical component for the state and the regions, and for the new managed care organizations that DHS will be contracting with for Medicaid programs. Kathy Johnson added that she thinks everyone shares responsibility for moving the system along. She said the community reinvestment fund that is part of the Magellan contract has been really useful for the services system and asked if there was anything similar included in the RFP. Rick responded that he would have to check the RFP language. Jane Hudson commented that there should be specific targets and outcomes for the contractors to use in building a community based system.

ID Waiver Waiting List & Regional Services – Patrick Schmitz read part of a letter Karen Walters-Crammond of Polk County Health Services shared with him. The letter was from DHS in response to an email from Karen asking if the Department expects regions to pay for services while an individual is on the ID Waiver waiting list.

The response read: “It is the Department’s expectation that eligible individuals should be able to apply through the region for services in your regional plans. The region will make the eligibility determination based on the region’s requirements. We do not assume that everyone on the waiting list qualifies for the ID waiver or for regional services. If they qualify for regional services in the regional plan we would expect that the region would fund these services.”

Patrick said his region is concerned about the financial impact of serving individuals on the waiting list and believe it could divert funding that would put other services currently in development at risk. He said he would like to hear what other regions are planning. Suzanne Watson said her region is trying to decide how it can be done in a consistent way. She said her region has determined that it cannot fund everyone for everything they want and are looking at how to define what constitutes an emergency or a crisis. They are considering that they may need to tell people who are in a stable situation that they will have to wait for waiver funding. Kathy Johnson said that approach is consistent with what has been discussed in her region. Ryanne Wood commented that it can be very difficult to project costs or know if people will follow through and contact their regions, but if they do, the regions will need to assess their needs.

Susanne Watson noted that a small group is meeting with Telligen this afternoon to discuss issues related to SIS (Supports Intensity Scale) assessments for people with intellectual disabilities because regions do not have access to that information. They want to talk about ways that the information can be shared or that regions can be trained to conduct assessments, without duplicating the work.

Pending Legislation – Theresa Armstrong shared information about bills in the legislature related to mental health and disability services:

- HF265 – This bill was just introduced this week. It would reestablish involuntary commitments for individuals with intellectual disabilities. The involuntary commitment process for persons with ID was removed from Iowa Code just a few years ago based on the recommendation of the statewide Judicial Workgroup.

Bills that have been assigned to subcommittee:

- HF68 – This bill would require each judicial district to establish a veterans' treatment court and jail diversion type activities for veterans based on mental health or substance use disorder treatment.

- HF 91 – This bill would provide for mental health advocates to be appointed by counties rather than by the court system. Currently MH advocates are paid for by the regions but are not employed or supervised by counties or regions. Under this proposal, the region would continue to pay for the advocates and they would be employed and supervised by the county, similar to other regional staff.

- HF170 – This bill is very similar to SF142, which has passed out of the subcommittee. It addresses older adults with aggressive or psychiatric behaviors and sexual offender issues in nursing facilities. It is focused on pulling together a stakeholder group together to look at options for facilities to serve this population.

- HF 251 – This bill is related to transportation for persons under commitment for mental illness or substance use. It would allow counties to contract with private entities to provide transport.

- SF156 – This bill is called Community Living for Older Adults and Individuals with Disabilities. It is based on Executive Order 27, which was signed by Governor Tom Vilsack in 2003 and established requirements for state agencies to collaborate on increasing access and removing barriers to community living for people with disabilities. This bill adds older adults. It calls for pulling together state agency representatives and other stakeholders to work on developing a plan and strategies. It would include participation by DHS, the Iowa Department on Aging, the Olmstead Consumer Task Force, and others.

- SF207 – This bill is related to interstate contracts for mental health services. It allows counties or regions to contract with providers in border states for involuntary commitments to psychiatric hospitals when the out of state facilities are closer than in-state hospitals. The other state must agree and Iowa's law on involuntary commitment would have to be respected in the other state. It also allows bordering states to contract with providers in Iowa.

- HF236 – This bill concerns the Iowa Prevention of Disabilities Policy Council, which under current law sunsets in July 1, 2015. This bill would make the council permanent and would add appointed members from DHS, the Department of Education, Department on Aging, and Department of Public Health.

- HF263 – This bill relates to inpatient psychiatric bed tracking and would move that effort forward as the report recommended last year.

SUBACUTE CARE DISCUSSION

Bob Lincoln, CEO of the County Social Services (CSS) Region, shared some information on Life Long Links, the collaboration regions are doing with AAAs (Area Agencies on Aging) to provide a centralized resource center. He said he is very excited about the launch and hopeful that it will be a great resource for people across the state.

Bob said he wanted to share some of his region's thoughts on addressing what they see as the lack of an institutional support system to communities. He said that over a decade ago when the state began reducing beds at state facilities, the availability of that resource as a safety net for community providers became more limited. He said law enforcement officials express frustration about having to take personnel away from other duties in order to transport individuals in crisis long distances to be admitted for psychiatric treatment. Bob said that when people with mental health needs are sitting in ERs or jail, or are transported long distances to find a hospital treatment bed, they are pulled away from their primary care doctors and primary support system.

The CSS region is considering trying to leverage identified subacute care level of beds to address those needs. They have been piloting the crisis stabilization project in Waterloo for three years. He said that it is the only thing open and available to them, which means they often want to use it beyond its capacity. Also, it has become more of a medical program, providing nursing care, and with a prescriber there three days a

week. Bob said they envision elevating the crisis stabilization unit in Waterloo to a subacute level of care and establishing a triage team whose primary focus would be civil commitments. He said this "assessment center" or "crisis center" could be a first contact, which would dispatch an integrated health home team, contact law enforcement, get the person to an appropriate care setting, and serve as a safety net when other options are not available. The approach would blend models they found in other states. The primary model is from Lincoln, Nebraska, which has a 15 bed crisis center that serves seven counties. All civil commitments are processed through that center, which is located on the campus of Bryan Memorial Hospital. Individuals stay on the unit for five to seven days through the process. They provide triage, hold a mental health court at the unit, and make an effort to engage the person in voluntary treatment at every step of the way.

Bob said there are some barriers to pursuing such a plan. Iowa's legislation governing the establishment of 50 new subacute care beds requires that an equal number of Iowa Code Chapter 135 hospital beds be identified and replaced. It also requires potential providers to submit a formal proposal to the Department. Beds have to be within an existing certificate of need, which are geographic.

Sharon Lambert asked how the mental health court would work. Bob responded that currently in Black Hawk County, a judicial referee fills the role of the judge for the mental health court. He said they envision having a room in the facility that could be the court setting, and also serve as place for family resolution meetings that could be used to try to resolve issues and bring the person into recovery. The goal would be to get people through the process and on to other services in five to seven days.

Patrick Schmitz asked how that would be different than crisis stabilization services. Bob responded that the director of the unit in Lincoln calls it crisis stabilization. In Nebraska, there is an identified reimbursement level of care through Magellan. It is also a locked unit. Patrick noted that crisis stabilization services in Iowa are voluntary.

Rick Shults said that the current Iowa Code sets limits that made sense at the time. Code limits the number of publicly funded subacute beds to 50, acquired through an RFP process, and associated with an established certificate of need. Since the time the legislation was passed, rules have been written to implement it and circumstances have changed. Rick said it is his understanding that there are some hospitals that are interested in offering subacute services, but may not want to give up beds for that purpose because of the lengthy process for certifying new ones. Bob said that if CSS were to move forward with this vision it would have to be with the support of the hospitals in the region. He said subacute services bring DIA into the picture because they are facility based and that provides oversight for risk management. Being able to have a unit locked would also add more security and safety for the people being served. He said the region would also want to provide 24-hour psychiatric availability, and would hope to be able to get Medicaid reimbursement. He said the region is currently providing 100% of the funding for crisis stabilization, and funding from HCBS waivers or

habilitation is not going to be available in facility settings. The vision is to push the current crisis stabilization services closer to the community and throughout the region.

Patrick asked if a single facility would cover the entire region, and if people would have to be transported for triage. Bob said he would like to build a response team to work with the subacute facility, and help people stay as close to home as possible. He said that several years ago Minnesota closed its larger facilities and built 16-bed acute care hospitals around the state. Their public beds are managed around a central intake process. People under orders of commitment are accepted, and voluntary patients are accepted if possible or are referred to other community providers. He said the region wants to expand capacity where it is needed and provide an institutional safety net, but do not want to compete with private providers.

Patrick asked Bob why he was not working to help service providers develop those services in hospitals and community mental health centers throughout his region. Bob responded that they want to build some regional infrastructure that will help people get what they need when they need it. He said they would like to have a triage process that helps get people with Alzheimer's, memory issues, substance use disorders, or intellectual disabilities to the services they need when commitment is not necessary. He said providers would be encouraged to come in and work with treatment teams to find placements after discharge. Bob said he estimates it will cost $1.5 to $2 million to increase this capacity in the long term, with the hope of reducing reliance on residential care facilities (RCFs).

Marissa Eyanson said that the program in Nebraska also has a wide array of other services and supports and asked Bob if he plans to build other services as well. Bob responded that is the intent.

MARCH MEETING

Rick Shults said that the Department will arrange for a more comprehensive presentation on the Medicaid Modernization RFP next month. Other suggestions for potential agenda items included transportation issues, implementation of federal HCBS rules, legislation, and the ID Waiver waiting list.

PUBLIC COMMENT

Eileen Creager shared brochures on Life Long Links. More information on aging and disability resources is available at: www.lifelonglinks.org or by calling 866-468-7887.

The meeting was adjourned at 1:05 p.m.

Minutes respectfully submitted by Connie B. Fanselow.